
New NHPCO Staffing Guidelines

Methods and Strategies for Success

Learning Objectives

- Increase knowledge and understanding of the new NHPCO Staffing Guidelines
 - Demonstrate an understanding of methods and concepts to utilize with the new NHPCO Staffing Guidelines
 - Describe NHPCO resources available to support the implementation of the new NHPCO Staffing Guidelines
 - Recognize the methods and benefits of the new NHPCO Staffing Guidelines for the hospice operation
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Quality & Standards Committee

■ History:

- ❑ Quality Initiative → Quality Partners
 - ❑ Quality Partners + Standards Committee = Quality and Standards Committee
 - ❑ 4 Task Forces of the Committee keep equal momentum and focus on QP & Standards (about 35 members-one of the largest committees)
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Quality & Standards Committee

- 4 Task Forces:
 - Standards of Practice
 - Quality Partners
 - Staffing Guidelines
 - Outcomes Measures



At the beginning---

NHPCO Hospice Service Guidelines

- History
 - NHPCO Standards and Accreditation Committee, 1994 last major revision
 - A tool to be used as an effort to reflect industry practice
 - Provide specific operational guidelines-benchmarks not incorporated into the Standards of Hospice Practice
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1994 Hospice Service Guidelines Review

- Included:
 - Admission and Discharge Policies & Practices
 - Levels of Care
 - **Staffing Ratios**
 - On-Call
 - Scope of Services
 - IDT, and contracted services
 - Facility-Based Services
 - Staffing Guidelines for Inpatient and Residential Care Facilities
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1994 Hospice Staffing Ratios



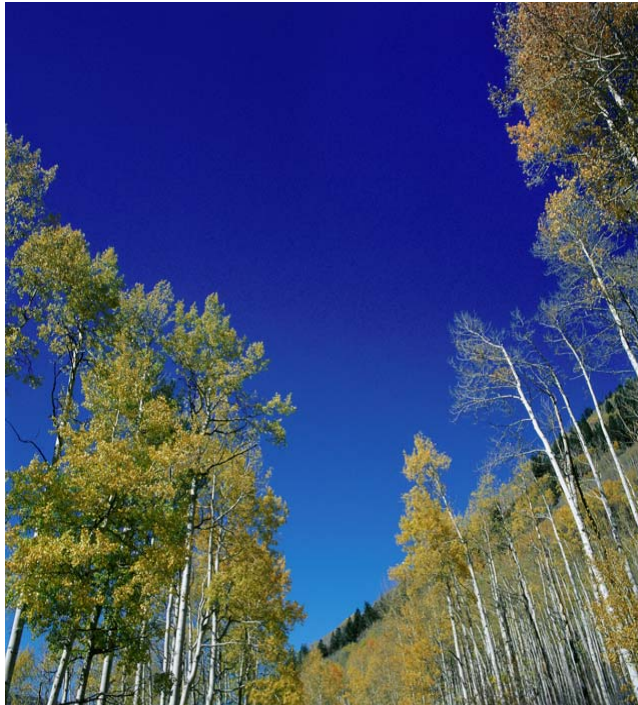
- Small sample of hospice programs determined staffing ratios
 - Consensus based on data and what was thought to be good practice at the time
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1994 Hospice Staffing Ratios

- Hospice data was sparse
- Hospice service models were more basic and uniform
- Patient population was different compared to our populations today



Staffing Ratios 2009: Starting the Discussion



- Where to begin?
 - Ratios vs caseloads?
 - No one “best practice” in literature regarding hospice staffing caseloads.
 - What’s the “correct” number?
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Staffing Ratios 2009: Starting the Discussion

- Decision made not to use a small task group, but entire Quality & Standards Committee for input
- Many discussions regarding starting points!



Staffing Ratios:



- Initial discussion:
 - What purpose do ratios/caseloads serve?
 - What would be expected outcomes of revision?
 - productivity-efficiencies?
 - financial concerns?
 - Do ratios/caseloads directly relate to quality of care or outcomes?
 - What about the various models of care hospice programs now have?

Key Consideration Issues

- Program size affect Rural vs urban programs?
- IPU units or strong continuous- care teams?
- Visit frequency vs ratios/caseload?
- Short term stay patients?
- Great discussion ratios/caseloads?
- of intensity of care vs. caseloads (intensity: hrs of care/acuity/case mix)



Bringing clarity to discussion

- Hospice Best Practice Guidelines
 - ❑ Looked at different processes of care (admission process, specialty teams, on-call, death process)
 - ❑ Compared these processes to best practices/processes known to date
 - ❑ Defined measures of outcomes/success via FEHC, FEBS, other tools to use as benchmarks with each of these processes of care
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Bringing Clarity to Discussion

- In discussing “Best Practices” -explored “Factors” which affect staffing in general
 - List developed- total of 90 factors!!
 - Each of these factors were listed describing how that factor could be a reason to support a lower or higher caseload.
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Bringing Clarity to Discussion



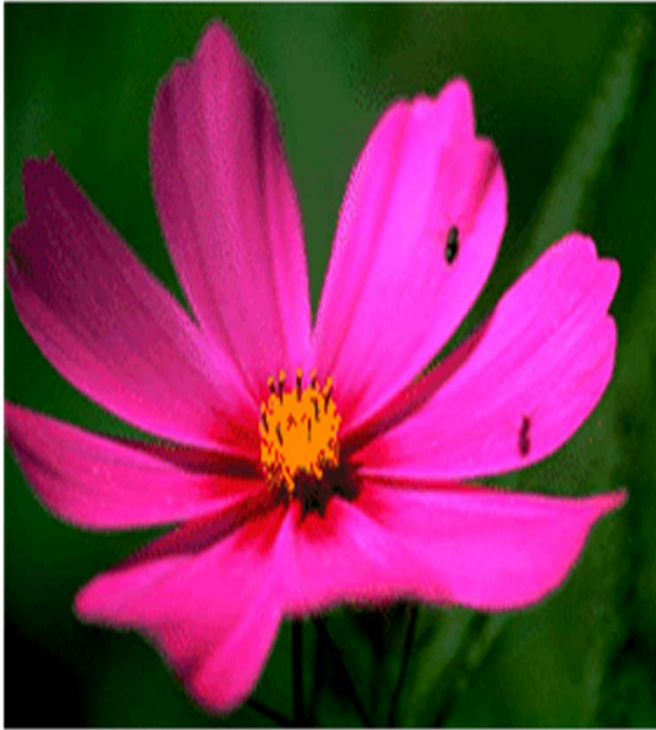
- If factor didn't really influence caseload, it was dropped from list.
 - Language: “staffing ratios” went away and “Caseload” became norm
 - Decision made not to be prescriptive
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Starting to take shape...

- Hospices have evolved and created diverse models of care to serve their patients & families.
- These models have been driven by a variety of factors in a hospice program.
- 90 factors were refined into 11 under 3 categories



However....



- *“The driving factor for hospices determining optimal staffing caseloads should be the ability to meet the needs of patients and families by appropriate use of resources while, at the same time, meeting the quality outcomes set by the hospice program.”*
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Determining Staffing Guidelines

- Hospices should utilize a planning process that includes:
 - Analysis of their care delivery models, or other models needed,
 - Characteristics of their patient population,
 - Environmental considerations,
 - Unique circumstances of their hospice program.
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NHPCO Staffing Guidelines

Resources

- Data Sets available for benchmarking:
 - National Summary of Hospice care (NDS)
 - Quality Partners Self-Assessment (SAS)
 - Family Evaluation of Hospice Care (FEHC)
 - Family Evaluation of Bereavement Services (FEBS)
 - Survey of Team Attitudes & Relationships (STAR)

 - Financial Benchmarks
 - Direct Labor Cost %, Patient Care Cost %, Indirect Cost %
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National Summary of Hospice Care (NDS)

- Contains national data and trends of hospice programs:
 - 19 Tables
 - Agency demographics
 - Patient demographics
 - Staffing management and delivery
 - Payer mix, Revenue & Expenses
- Updated annually
- Descriptive data, not predictive or prescriptive



Staffing Guidelines Analysis



- Staffing caseloads have to be considered in light of other program factors that may affect staffing caseloads beyond the data provided in the NDS.
- This is only a starting point in planning, not endpoint.

Staffing Guidelines Analysis

- Any staffing matrix implemented must ensure:
 - Continuous ongoing assessment
 - the needs of patients and families are being met, (benchmark performance with FEHC & FEBS)
 - staff are able to perform at an optimal level, (use STAR survey results)
 - quality outcomes are met (QP & SAS & QAPI)
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The New NHPCO Hospice Staffing Guidelines



- Provides a tool to assist in the analysis of each hospice's particular characteristics and design
- Use national data for comparative analysis

Hospice Staffing Guidelines

- 3 Main Categories:
 - Length of Stay Characteristics
 - Staffing Model Characteristics
 - Organizational Characteristics
 - 11 Additional Benchmark Factors
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Length of Stay Characteristics

- Short length of service
 - Measured by percentage of patient discharges within first seven days
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<i>Length of Stay Characteristics</i>	<i>Consider smaller caseload</i>	<i>Consider larger caseload</i>
Short Length of Stay (% D/C 7 or less days) (NDS Table 7)	Above mean (34.4%)	Below mean (34.4%)

Organizational Characteristics

- Percent of routine level of care
 - Access to care/impact on patient acuity (presence of disease-modifying therapy)
 - Aide/homemaker delivery model measured by hospice aide FTE
 - Use of ancillary therapy (art, massage, music, PT/OT)
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Organization Characteristics

<i>Organization Characteristics</i>	<i>Consider smaller caseloads</i>	<i>Consider larger caseload</i>
% of routine LOC (NDS Table 9)	Below average (95.9%)	Above average (95.9%)
Access	Open access (disease-modifying therapies encouraged)	Restricted access (disease-modifying therapies discouraged)
Aide/Home-maker delivery model (NDS Table 11)	Aide distribution below mean (18.1% of home hospice FTE's)	Aide distribution above mean (18.1%)
Use of ancillary services (art, music, massage, PT, OT)	Not routinely used	Routinely used

Other Factors/Considerations

- Availability of Continuous Care
 - May support a higher than mean caseload for IDT, but RN supervisory duties may be higher

 - Availability of GIP
 - May support a higher than mean caseload for RN, as high intensity patients may be shifted to IPU.
 - Contracted GIP beds may support a lower than mean caseload for RN as visit frequency is higher for these higher acuity patients.
 - Non easy access to GIP may support lower than median caseloads
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Other Factors/Considerations

- Availability of Respite Care
 - Nursing Home Teams
 - Primary/Shared Team Model
 - Multiple Roles for the IDT
 - Specialty Programs
 - Travel Time Issues
 - Rate of Growth
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Staffing Model Characteristics

- Admission Model
 - On Call Model
 - RN/LPN Model-sharing partnership
 - Shared Team/Primary Care Team Model
 - Bereavement Model
 - Staff Turnover rate
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- [+] Indicates possible ability to sustain higher than median caseload
 - [-] Indicates possible need to support lower than median caseload
 - [=] Indicates neutral impact of factor on caseload, may likely approximate median
-

Staffing Model Characteristics

<i>Staffing Model</i>	<i>Consider smaller caseload</i>	<i>Consider larger caseload</i>
Admission Model	Does not use Admission Specialist	Uses Admission Specialist (49.4% use)
On Call Model	Does not use dedicated on-call staff	Uses dedicated on-call staff
RN/LPN Model-sharing partnership	Not in use	In use (for the RN case manager)
Shared Team-Primary Team Models	Not in use	In use, IDT takes on tasks to reduce RN workload
Bereavement model	IDT performs bereavement follow up	Dedicated bereavement staff follow up
Staff turnover rate (NDS Table 11)	Above mean (25.5% all clinical)	Below mean (25.5% all clinical)

Staff Management

Caseloads by Discipline NDS Table: 14

<i>Patient Caseload</i>	<i>Agency Mean</i>	<i>25TH%</i>	<i>Median</i>	<i>75%</i>
Nurse Case Manager	10.8	9	11	13
SW	24	17.4	25	30
HHA	9.8	6	10	12
Chaplains	32.7	15	30	50

Hospice Program Examples Using Staffing Guidelines Table

- [+] Indicates possible ability to sustain higher than median caseload
 - [-] Indicates possible need to support lower than median caseload
 - [=] Indicates neutral impact of factor on caseload, may likely approximate median
-

Example Hospice D: Staffing Analysis

- **Census: >100-120 ADC**
 - **RN 12 , SW 25, SCC 40, Aide 12**
 - **Factors:**
 - Dedicated team Clinical Supervisors to support team in- house patient calls and in field
 - Dedicated admissions specialist
 - Dedicated clinician based on-call triage service
 - Travel distances manageable
 - Volunteer Program with complementary therapies (music, massage) (QP SAS)
 - HHA distribution above mean of 18.5% (NDS)
 - Direct General Inpatient Delivery in the community
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Example Hospice D

- ❑ Continuous Care Delivery
 - ❑ Veterans Program integration
 - ❑ Dedicated Bereavement Team with Social Work intervention (QP SAS)
 - ❑ Above 30.8% mean LOS less than 7 days (NDS)
 - ❑ Staff turnover below 31.6% mean (NDS)
 - ❑ Restrictive access/no palliative care program
 - ❑ Quality Indicators at or above National Benchmarks (FEHC, FEBS)
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Bristol - Hospice D

Staffing Analysis

- Bi weekly review of operational and clinical outcomes to ensure quality and financial strength
 - Continue aggressive ongoing monitoring of growth and market expansion to ensure staffing needs align with the patient /family acuity needs and level of care delivery.
 - Ongoing evaluation of staffing needs r/t part time or PRN staff to support IDT model during growth and expansion, to include Continuous Care and General Inpatient Delivery
 - Integrate specialized program to support community disease specific needs in hospice care
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Hospice E-Staffing Analysis

- **Census: < 50 ADC**
 - **RN 10, SW 30, SCC 40, Aide 10**
 - **Factors**
 - Dedicated Clinical Supervisor supports staff in-house patient calls and direct field
 - IDT performs full admissions – Social Work/RN Team
 - RN 24 hour follow up visit following admission (FEHC)
 - RN covers rotating on call
 - Dedicated clinical based triage service for on-call
 - Integrated team bereavement program (FEBS)
 - Above median LOS of 30.8% less than 7 days (NDS)
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Hospice E

- Aggressive community Volunteer Program Support (QP SAS)
 - SCC caseload slightly lower due to growing census
 - Staff turnover below mean of 31.6% (NDS)
 - HHS distribution above 18.5% mean (NDS)
 - Direct General Inpatient Delivery in community
 - Quality Indicators at or above National Benchmarks (FEHC, FEBS)
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Hospice E Staffing Analysis

- Bi weekly review of operational and clinical outcomes to ensure quality and financial strength
 - Aggressive ongoing monitoring of growth and market expansion to ensure staffing needs align with the patient /family acuity needs and level of care delivery.
 - Ongoing evaluation of staffing needs r/t part time or PRN staff to support IDT model during growth and expansion
 - Ongoing evaluation of the on call delivery to determine need for fulltime on call staffing
 - Continue to evaluate patient/family response to shared team approach and cost controls and efficiencies.
 - Expand Bereavement and complementary therapies to support IDT delivery
 - Integrate specialized program to support community disease specific needs in hospice care
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Example Hospice F

Inpatient
Services

34-bed facility additional
10-bed facility

May 2011

Home Hospice
Care

Harford County
Baltimore South
Baltimore East
Central
Baltimore West
Howard

Facility-Based
Care

FBC-East
FBC-Central
FBC-West

Example Hospice F:Staffing Analysis

- Census: 286
- Staffing RN 10, SW 25-30, Chaplain 55, Aides 10

FACTORS:		COMMENTS:
- SLOS 34.4%	+	28%
Admission Model	+	
On Call Model	+	
RN/LPN Model	-	
Shared Team Model	-	
Bereavement Model	+	
Staff Turnover 25.5%	+	12%
Percent Routine LOC 90%	+	
95.9		
Access		
Expanded Care Program	-	
Hospice Aide FTE	+	
Use of ancillary Therapy	=	

OTHER FACTORS		COMMENTS
GIP AND Continuous Care	+	
Multiple Non Core Roles for IDT	+	
Facility Based Variables	+	
Primary Care Team Model	-	Multiple intrusive calls- That is throughout the work day.
Provision of Community Services	+	
Psychosocial Issues: high social complexity	=	With Exception of Central Team
Rate of Growth	=	
Specialty Programs	+	
Spiritual Care Support Model	+	
Staff Safety	+	With Exception of Central Team
Travel Time	=	
Volunteer Utilization	=	

Other:

Quality measures remain at or above national benchmarks.

Staff satisfaction surveys of 72% exceeds national means of 69% and scores of previous years.

Summary Analysis

- Current Caseload numbers reflect a reasonable level when compared to the NDS. Driving factors are the predominant role of admissions team, and strong bereavement department.
 - Increasing caseloads might be considered with addition of triage role to manage calls during the workday. These interruptions are a frequent complaint of staff and observed to be intrusive by managers when making supervisory visits.
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Summary Analysis Continued

- Consideration should be given to staffing the Central Team differently than the rest of the division due to safety issues and the complexity of psychosocial scenarios.
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Example Hospice G: NH Team Staffing Analysis

- Census: 210
- Staffing: RN 10, SW 25-30, Chaplains 55, Aides 10

FACTORS:		COMMENTS:
SLOS~ 34.4%	+	28%
Admission Model	-	
On Call Model	+	
RN/LPN Model	=	In Pilot Phase
Shared Team Model	-	
Bereavement Model	+	
Staff Turnover 25.5%	+	12%
Percent Routine LOC 90%	+	98%
95.9		
Access	=	
Hospice Aide FTE	+	
Use of ancillary Therapy	=	

OTHER FACTORS**COMMENTS**

GIP AND Continuous Care	+	
Multiple Non Core Roles for IDT		~Interdisciplinary attendance at all facility care plan meetings. ~Staff assigned to facilities responsible for ongoing facility education.
	-	Multiple and varied levels of communication and coordination
Facility Based Variables	-	Multiple intrusive calls- That is throughout the work day.
Primary Care Team Model	-	
Provision of Community Services	+	
Psychosocial Issues: high social complexity	+	
Rate of Growth	=	
Specialty Programs	+	
Spiritual Care Support Model	-	Plan and conduct regularly memorial celebrations by facility
Staff Safety	-	
Travel Time	=	With Exception of FBC West
Volunteer Utilization	=	

Other:

Quality measures remain at or above national benchmark.

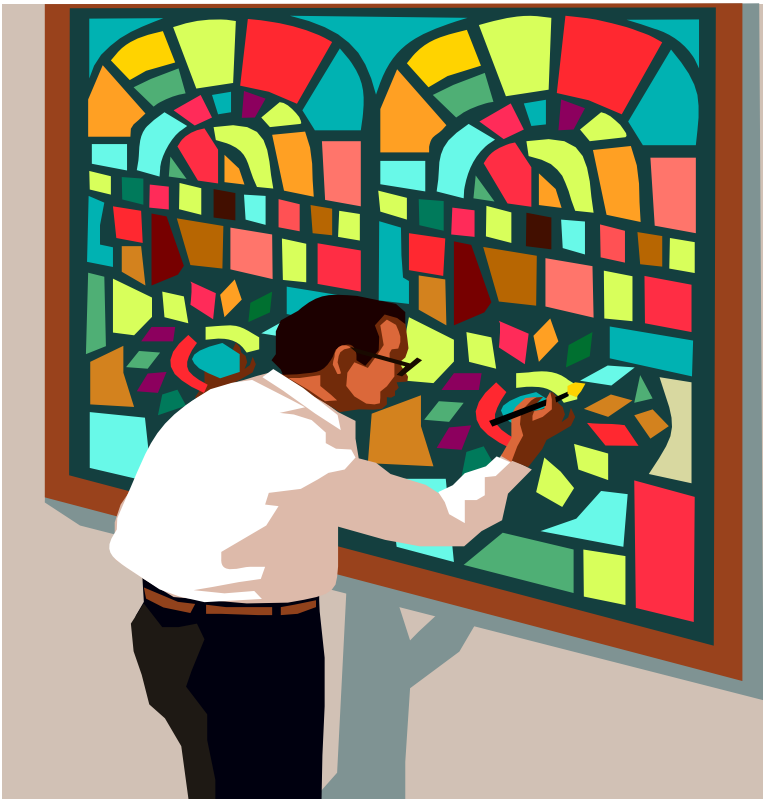
Staff Satisfaction survey of 72% exceeds national mean of 69% and scores of previous years.

Summary Analysis

- Current caseload numbers may reflect an unreasonable level when compared to the NDS.
 - Driving factors to reduce caseload numbers include staff doing their own admissions, non-core roles assumed by IDT, multiple levels of communication and coordination and staff responsibility for educational offerings.
 - Additionally the impact of excessive travel must be considered for the West team.
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Review

- History of Staffing Ratios/Caseloads
 - Today's models of hospice care delivery
 - Caseload Analysis Planning
 - Staffing Guidelines Worksheet
 - Ntl Hospice Summary of Care Tables Use
 - Other Factors to consider in staffing caseloads
 - Hospice Examples
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“People are like stained-glass windows. They sparkle and shine when the sun is out, but when the darkness sets in, their true beauty is revealed only if there is a light from within.”

Elizabeth Kubler-Ross

Contact Information

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